Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

I. Request Information

A. The **State** of **Massachusetts** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Waiver Title (*optional*): MFP – Community Living

C. CMS Waiver Number: MA.1027

D. Amendment Number (*Assigned by CMS***):**

E.1 Proposed Effective Date: 09/01/2016

E.2 Approved Effective Date *(CMS Use):*

II. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

This amendment makes technical revisions to the target group criteria to reflect the phase-out of the Money Follows the Person Demonstration; adds slot capacity in waiver years 4 and 5; adds Transitional Assistance and Orientation and Mobility as participant services, and updates the unit types for Day Services. The cost neutrality demonstration is updated accordingly. In addition, this amendment addresses Fair Labor Standards Act (FLSA) requirements applicable to self-directed services.

III. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

	Component of the Approved Waiver	Subsection(s)
☑	Waiver Application	Public Input, Contacts, Attachment 2
☐	Appendix A – Waiver Administration and Operation	
☑	Appendix B – Participant Access and Eligibility	B-1-b, B-3-a, B-3-c
☑	Appendix C – Participant Services	C-1-a, C-1/C-3, C-5
☐	Appendix D – Participant Centered Service Planning and Delivery	
☑	Appendix E – Participant Direction of Services	E-1-a
☐	Appendix F – Participant Rights	
☐	Appendix G – Participant Safeguards	
☑	Appendix I – Financial Accountability	I-2-a
☑	Appendix J – Cost-Neutrality Demonstration	J-1, J-2-a, J-2-b, J-2-c, J-2-d

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☑	Modify target group(s)
☐	Modify Medicaid eligibility
☑	Add/delete services
☑	Revise service specifications
☐	Revise provider qualifications
☑	Increase/decrease number of participants
☑	Revise cost neutrality demonstration
☐	Add participant-direction of services
☐	Other (specify):

IV. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding this amendment is:

First Name:	Amy
Last Name	Bernstein
Title:	Director, Community Based Waivers
Agency:	MassHealth
Address 1:	One Ashburton Place
Address 2:	11th Floor
City	Boston
State	MA
Zip Code	02108
Telephone:	(617) 573-1751
E-mail	Amy.Bernstein@state.ma.us
Fax Number	(617) 573-1894

B. If applicable, the operating agency representative with whom CMS should communicate regarding this amendment is:

First Name:	~~Kerri~~ Josh
Last Name	~~Zanchi~~ Mendelson
Title:	Assistant Commissioner, Community Living
Agency:	Massachusetts Rehabilitation Commission
Address 1:	600 Washington St.
Address 2:	
City	Boston
State	MA
Zip Code	02111
Telephone:	
E-mail	
Fax Number	

V. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: _____ **Date:**

State Medicaid Director or Designee

First Name:	Daniel
Last Name	Tsai
Title:	Assistant Secretary and Director of MassHealth
Agency:	Executive Office of Health and Human Services
Address 1:	One Ashburton Place
Address 2:	11th Floor
City	Boston
State	MA
Zip Code	02108
Telephone:	
E-mail	
Fax Number	(617) 573-1894

6. Additional Requirements

I. Public Input. Describe how the State secures public input into the development of the waiver:

~~Massachusetts submitted a Statewide HCBS Transition Plan on February 27, 2015 in response to the Centers for Medicare and Medicaid Services (CMS) March 17, 2014 final rule related to Medicaid long term services and supports provided in home and community-based settings. The state engaged in an extensive process to obtain public review and input of this plan, including: formation of stakeholder groups; convening an interagency workgroup to address the new federal HCB settings requirements; posting the state's draft Statewide HCBS Transition Plan on the MassHealth website; publication in multiple newspapers of the public input period and publication of an email and regular mail address for submission of comments; emailing a notice to several hundred people, including key advocacy organizations and the Native American tribal contacts, and conducting two public forums. The draft Statewide HCBS Transition Plan as well as these HCBS waiver amendments have been and continue to be discussed during the quarterly conference calls with the tribal representatives.~~

2015 Amendment:

Massachusetts outreached broadly to the public and to interested stakeholders to solicit input on this MFP-CL waiver amendment. The waiver was posted to MassHealth's website, and public notices were issued in multiple newspapers, including: the Boston Globe, Worcester Telegram and Gazette, and the Springfield Republican. In addition, emails were sent to several hundred recipients, which included key advocacy organizations as well as the Native American tribal contacts. The newspaper notices and email provided the link to the MassHealth website that includes the draft MFP-CL amendment, the public comment period, and, for anyone wishing to send comments, both email and mailing addresses. No written comments were received either through email or mail. In addition, feedback on this waiver amendment was solicited at the ABI/MFP/TBI Stakeholder Advisory Committee meeting, a community meeting involving waiver participants and from a group of waiver service providers. Overall feedback at these meetings was positive, no specific changes to the amendments were suggested.

2016 Amendment:

Massachusetts outreached broadly to the public and to interested stakeholders to solicit input on this MFP-CL waiver amendment. The waiver was posted to MassHealth's website, and public notices were issued in multiple newspapers, including: the Boston Globe, Worcester Telegram and Gazette, and the Springfield Republican. In addition, emails were sent to several hundred recipients, which included key advocacy organizations as well as the Native American tribal contacts. The newspaper notices and email provided the link to the MassHealth website that includes the draft MFP-CL amendment, the public comment period, and, for anyone wishing to send comments, both email and mailing addresses.

Massachusetts engaged in an extensive public input process in order to develop its Money Follow the Person demonstration grant application and continues to engage with stakeholders as it implements the demonstration. The MFP-CL waiver is a key component of the state's implementation of its MFP demonstration. Outreach by the Office of Medicaid (OOM), and the Massachusetts Rehabilitation Commission (MRC) began in 2010. Ongoing outreach continues through semi-annual MFP Stakeholder Meetings and on-going meeting with MFP contractors serving as MFP Transition Entities, demonstration service providers, and/or waiver service providers. The MFP Demonstration staff and staff associated with related waivers maintain a mailing list of over 200 interested persons and organizations. The list includes Native American Tribal contacts, and representatives from

Advocacy Agencies, Human Service Provider Agencies, Community Support Providers, Aging and Disability Resource Consortia (ADRC) partners (which include Independent Living Centers, Area Agencies on Aging/Aging Services Access Points), multiple State Human Service Agencies, and individuals with disabilities. The stakeholder meetings are well attended and provide positive feedback about the MFP waivers. Through the MFP Demonstration, EOHHS is now working with Transition Entity contractors to promote transition of MFP qualified individuals. These stakeholders have created a grass roots effort to outreach to potential MFP qualified individuals, and therefore to potential MFP waiver participants. Communication with and training opportunities for these entities, is on-going and includes extensive information about the MFP-CL and other waivers.

Since January 2011, MassHealth has outreached to and communicated with the Tribal governments about the Money Follows the Person (MFP) Demonstration and related Waivers, including this MFP-CL waiver at each of their regularly scheduled tribal consultation quarterly meetings. The tribal consultation quarterly meetings have afforded direct discussions with Tribal government contacts about this amendment. The Tribal government contacts were also added to the MFP interested stakeholders e-mail distribution list so they receive regular notifications of all MFP meetings. The tribal governments have not offered any comments or advice on the MFP Demonstration, or this waiver to MassHealth staff.

The state will continue to work with stakeholders and to obtain ongoing input from public forums about the MFP-CL waiver.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of

updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Massachusetts Executive Office of Health and Human Services (EOHHS), the single State Medicaid Agency convened an interagency workgroup to address how best to comply with the requirements ~~of the requirements~~ of the federal Home and Community Based (HCB) settings rule at 42 CFR 441.301 (c)(4)-(5) (the Community Rule). The Massachusetts Rehabilitation Commission (MRC), an agency within EOHHS who has primary responsibility for day-to-day operation of the MFP-CL waiver, was a member of the workgroup. All regulations, policies, standards, certifications and procedures have been reviewed against the Community Rule HCBS Regulations and necessary changes identified. Details are provided in the Systemic Assessment section of the Statewide Transition Plan (STP).

Participants in the MFP-CL Waiver live in their own homes or apartments, or in homes and apartments with family members and other informal supports. These settings are considered to fully comply with the HCBS Regulations.

Waiver services delivered to the participant in their home (for example personal care, homemaker, and chore services) ~~were~~ are also considered to be fully compliant with the HCBS Regulations.

Adult Companion services and Individual Support and Community Habilitation services may be delivered either in the participant's home or in the community. Transportation services by definition assist the participant in engaging in waiver or other services in the community and in other community activities. As such these services are all considered to be fully compliant with the HCBS Regulations.

As described in detail in the Statewide Transition Plan, DDS developed and distributed a survey to providers of day services in collaboration with the Massachusetts Rehabilitation Commission (MRC). DDS staff reviewed survey results along with site-specific program data for providers that contract with both DDS and MRC. Based on this review, it was determined that all of the day services providers that contract with both DDS and MRC require some level of modification to come into full compliance with the Community Rule. Details on remedial actions are provided in the Site-Specific Assessment section of the STP, and transition milestones are summarized in Table 3 of the STP.

For the eight employment providers that are not licensed or certified by DDS, MRC reviewed the credentialing information gathered by UMMS-PNA to ensure each setting's fidelity to the service model of individualized supported employment in integrated community settings. The assessment process for the 29 providers licensed or certified by DDS involved DDS review of site-specific data, including licensure and certification information, with focus on the experiences of individuals within each setting. MRC determined, through its review, that all employment providers for the MFP-CL waiver that are not licensed or certified by DDS fully comply with the Community Rule. State-wide, all group employment settings that are licensed or certified by DDS require some level of modification to achieve full compliance with the Community Rule, particularly regarding policies or practices in one or more of the following domains: meaningful integration into the workplace; access to workplace amenities to the same degree as non-disabled workers; and assurance that individuals are earning at least the minimum wage. Details on Remedial Actions are provided in the Site-Specific Assessment section of the STP, and transition milestones are summarized in Table 3 of the STP.

~~Further review and assessment of the settings in which the following waiver services are provided is currently underway: Day Services, Prevocational Services and Supported Employment Services.~~

~~Additional details regarding the process used to review HCBS Settings types and whether they comply with~~

~~the HCBS Regulations may be found in the Statewide Transition Plan submitted to CMS on February 27, 2015 and the Addendum to the Statewide Transition Plan currently under review and anticipated to be submitted to CMS shortly.~~

~~Concurrent with the systemic review of regulations, policies and procedures and provider qualification processes, all providers of community based day support services have been sent a survey that incorporates questions that enable a provider to assess where they are in the continuum of outcomes necessary to meet the requirements of the Community Rule.~~

~~Survey data has not as yet been received. Once received, it will be aggregated, reviewed, and analyzed to determine any changes needed to fully comply with the requirements of the Community Rule. Data gleaned from the surveys will inform the existing Employment Work Group as well as a recently formed group of stakeholders regarding:~~

~~a. The development of definitions and standards for what constitutes a meaningful day service;~~
~~b. The incorporation of both qualitative and quantitative measures into the DDS licensure and certification process to ensure providers fully comply with the HCBS Regulations;~~
~~c. The modification of the MRC monitoring tool to reflect changes in program expectations and standards to ensure providers fully comply with the HCBS Regulations;~~
~~d. Systemic strategies to assist all community based day service providers to achieve the outcomes of the Community Rule including but not limited to technical assistance and staff development and training.~~

~~Findings will be validated through ongoing Licensure and Certification processes or, for those providers not subject to Licensure and Certification, through responses to a Request for Response (RFR) and ongoing program monitoring.~~ All waiver providers will be subject to ongoing review on the schedule outlined in Appendix C of the waiver application.

~~The state anticipates development of clear guidelines and standards that define day services, including what constitutes meaningful day activities, and how services and supports can be integrated into the community more fully. Technical assistance, training and staff development will be provided to assist providers in complying with the HCBS Regulations.~~

Individuals receiving services in settings that cannot meet requirements will be notified by the state agency providing case management. The case manager will review with the participant the services available and the list of qualified and fully compliant providers, and will assist the participant in choosing the services and providers, from such list, that best meet the participant's needs and goals.

For all settings in which changes will be required, MRC will institute a process to assure that the changes occur. This process will include consultation and support to providers to enable them to successfully transition, quarterly reporting by providers to update MRC on progress towards compliance, and reviews by designated MRC staff to assure adherence to transition plans and processes.

All settings in which waiver services are delivered will be fully compliant with the HCBS Regulations no later than March 16, 2019. Additional information on transition milestones is provided in Table 3 of the STP.

~~Massachusetts outreached to the public to solicit input on this ABI-RH waiver amendment through multiple formats. The waiver was posted to MassHealth's website and newspaper public notices were issued in the Boston Globe (July 8, 2016March 14, 2015), Worcester Telegram and Gazette (July 8, 2016March 17, 2015), and the Springfield Republican (July 8, 2016March 17, 2015). In addition, emails were sent on March 13, 2015 to several hundred recipients, which included key advocacy organizations as well as the Native American tribal contacts. The newspaper notices and email provided the link to the MassHealth website that includes the draft ABI-RH amendment, the public comment period, and, for anyone wishing to~~

~~send comments, both email and mailing addresses. The waiver amendment was also discussed in the quarterly conference call with tribal representatives held on February 5, 2015.~~

Massachusetts ~~also~~ has engaged in an extensive process to obtain public review and input of ~~their HCBS~~the Massachusetts Statewide Transition Plan (STP), as described in detail in the STP submitted to CMS in September 2016.~~including: formation of stakeholder groups; convening an interagency workgroup to address the new federal HCB settings requirements; posting the state's draft Statewide HCBS Transition Plan on the MassHealth website from October 15, 2014 through the close of the public comment period on November 15, 2014; publication in multiple newspapers of the public input period and publication of an email and regular mail address for submission of comments (published in the Boston Globe, Worcester Telegram and Gazette and Springfield Republican on October 15, 2014); emailing a notice to several hundred people (October 16, 2014), including key advocacy organizations and the Native American tribal contacts, and conducting two public forums (November 6, 2014 and November 12, 2014) at which oral comments were heard and noted.~~

~~The Addendum to the Statewide Transition Plan has been publicized in the same fashion: posted on the MassHealth website from May 15, 2015 through the close of the public comment period on June 18, 2015; publication in multiple newspapers of the public input period and publication of an email and regular mail address for submission of comments (published in the Boston Globe, Worcester Telegram and Gazette and Springfield Republican on May 18, 2015); emailing a notice to several hundred people (May 15, 2015 with a reminder email sent on June 8, 2015), including key advocacy organizations and the Native American tribal contacts, and conducting a public forum (June 1, 2015).~~

The State is committed to transparency during both the STP planning and~~phase and the~~ implementation phases to comply with the HCB setting requirements. If, in the course of ongoing monitoring process, MRC along with MassHealth determines that additional substantive changes to the Transition Plan are necessary, MassHealth and MRC will engage in activities that include: publication of draft plan for 30 days with the opportunity for comments to be submitted to the agencies, as well as review/comment by the agencies on all input received.

The State assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to the waiver when the next amendment or renewal is submitted.

Appendix B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Select one Waiver Target Group	Target Group/Subgroup		Minimum Age	Maximum Age	
				Maximum Age Limit: Through age –	No Maximum Age Limit
☑	**Aged or Disabled, or Both - General**				
	☑	Aged (age 65 and older)	65		☑
	☑	Disabled (Physical)	18	64	
	☐	Disabled (Other)			
☐	**Aged or Disabled, or Both - Specific Recognized Subgroups**				
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐	**Intellectual Disability or Developmental Disability, or Both**				
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
☑	**Mental Illness** *(check each that applies)*				
	☑	Mental Illness	18	64	☐
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The State further specifies its target group(s) as follows:

The target group for this waiver includes adults, age 18 and over, with both physical disabilities and mental illness.

Applicants to the MFP Community Living (MFP-CL) Waiver must also meet the following program criteria to participate in the waiver:
1. Reside (and have resided for a period of not less than 90 consecutive days~~, excluding Medicare rehabilitation days~~) in an inpatient facility (specifically a nursing facility, chronic disease or rehabilitation hospital, or, for participants 18 through 21 years of age or 65 years of age and older, a psychiatric hospital~~MFP qualified facility~~);
~~2. Meet the requirements for participation in the MFP Demonstration;~~
~~3~~2. Meet the level of care criteria as specified in Appendix B.6.d.;
~~4~~3. Be able to be safely served in the community within the terms of the MFP-CL Waiver;
~~5~~4. In transitioning to the community setting from a facility, move to a ~~MFP~~ qualified residence (i.e. a ~~home owned or leased by the applicant or family member, an apartment with an individual lease or a community-based residential setting in which no more than 4 unrelated individuals reside)~~setting that meets the applicable requirements of the Community Rule (42 CFR 441.301(c)(4)).

~~The state has defined MFP Qualified Facilities for the MFP Demonstration as all Massachusetts Department of Public Health (DPH) licensed and Medicaid certified nursing facilities (NFs), chronic disease and rehabilitation hospitals, and Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/IID) as well as all Department of Public Health Hospitals in the Commonwealth, and for Enrollees 18-21 and 65 and older, Institutions for Mental Disease (IMDs). For purposes of this waiver these facilities would include nursing homes, chronic disease and rehabilitation hospitals, public health hospitals and IMDs (limited to enrollees 18-21 and 65 and older).~~

~~MFP Demonstration qualified participants receiving services from another 1915(c) waiver or receiving State Plan services~~ The following individuals may request a transfer to the MFP-CL waiver~~.~~: MFP-RS, ABI-RH, and ABI-N Waiver Participants; ~~This shall include participants who have completed their participation in the MFP Demonstration.~~ MFP Demonstration qualified participants within their MFP Demonstration period; and MFP Demonstration qualified participants within 180 days of the conclusion of their MFP Demonstration period. These applicants will be considered to have met the criteria in item~~s~~ 1 ~~and 2~~ above.

Appendix B-3: Number of Individuals Served

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	125
Year 2	240
Year 3	350
Year 4 (only appears if applicable based on Item 1-C)	~~464~~564
Year 5 (only appears if applicable based on Item 1-C)	~~579~~729

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

○	**Not applicable**. **The state does not reserve capacity.**

● **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Waiver Transfer

Table B-3-c

	Purpose (provide a title or short description to use for lookup):
	Waiver Transfer
	Purpose (describe):
	The state reserves capacity for individuals who have been receiving service from another 1915(c) waiver or receiving State Plan services who now require the services of the MFP-CL waiver to meet their needs. MFP-RS, ABI-RH, and ABI-N Waiver ~~MFP Demonstration~~ Participants, and MFP Demonstration Participants within their MFP Demonstration period or up to 180 days thereafter, who request a transfer to the MFP-CL Waiver will be considered to have met the additional targeting criteria outlined in Appendix B-1-b item~~s~~ #1 ~~and #2~~. All such individual must meet the remaining eligibility criteria as outlined in Appendix B-1-b.
	Describe how the amount of reserved capacity was determined:
	The reserved capacity is an estimate of anticipated need for waiver transfers and will be adjusted if necessary based on actual experience.
Waiver Year	**Capacity Reserved**
Year 1	3
Year 2	3
Year 3	3
Year 4 (only if applicable based on Item 1-C)	3
Year 5 (only if applicable based on Item 1-C)	3

Appendix C-1/C-3: Summary of Services Covered and Services Specifications

C-1-a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	☐	
Homemaker	☑	
Home Health Aide	☑	
Personal Care	☑	
Adult Day Health	☐	
Habilitation	☐	
Residential Habilitation	☐	
Day Habilitation	☐	
Prevocational Services	☑	
Supported Employment	☑	
Education	☐	
Respite	☑	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
●	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Addiction Services
b.	Adult Companion
c.	Chore Service

d.	Community Crisis Stabilization
e.	Community Family Training
f.	Community Psychiatric Support and Treatment (CPST)
g.	Day Services
h.	Home Accessibility Adaptations
i.	Independent Living Supports
j.	Individual Support and Community Habilitation
k.	Medication Administration
l.	Occupational Therapy
m.	Orientation and Mobility Services
~~mn~~.	Peer Support
~~no~~.	Physical Therapy
~~op~~.	Shared Home Supports
~~pq~~.	Skilled Nursing
~~qr~~.	Specialized Medical Equipment
~~rs~~.	Speech Therapy
~~st~~.	Supportive Home Care Aide
u.	Transitional Assistance Services
~~tv~~.	Transportation
~~uw~~.	Vehicle Modification

C-1/C-3: Service Specification

Service Specification					
Service Definition (Scope)**: Orientation and Mobility Services**					
Orientation and Mobility (O&M) services teach an individual with vision impairment or legal blindness how to move or travel safely and independently in his/her home and community and include (a) O&M assessment; (b) training and education provided to Participants; (c) environmental evaluations; (d) caregiver/direct care staff training on sensitivity to blindness/low vision; and (e) information and resources on community living for persons with vision impairment or legal blindness. O&M Services are tailored to the individual's need and may extend beyond the home setting to other community settings as well as public transportation systems.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐ Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Certified Orientation and Mobility Specialists (COMS)		Human Service Agencies	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Certified Orientation and Mobility Specialists (COMS)		Individual providers of Orientation and Mobility Services must have a master's degree in special education with a specialty in orientation and mobility or a bachelor's degree with a certificate in orientation and mobility from an ACVREP (Academy for Certification of Vision Rehabilitation and Education Professionals) - certified university program.	Individuals providing services must also have: - Knowledge and experience in the evaluation of the needs of an individual with vision impairment or legal blindness, including functional evaluation of the individual in the individual's customary environment. - Knowledge and/or experience in educating caregivers or direct care staff, or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with vision impairment or legal blindness, in sensitivity to low vision/blindness.
Human Service Agencies		Individual providers and individuals employed by the agency providing Orientation and Mobility Services must have a master's degree in special education with a specialty in orientation and mobility or a	Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following:

		bachelor's degree with a certificate in orientation and mobility from an ACVREP-certified university program.	- Providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to perform assigned duties and responsibilities. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. Staff providing services must have: - Master's degree in special education with a specialty in orientation and mobility; or - Bachelor's degree with a certificate in orientation and mobility from an ACVREP certified university program Individuals providing services must also have: - Knowledge and experience in the evaluation of the needs of an individual with vision impairment or legal blindness, including functional evaluation of the individual in the individual's customary environment. - Knowledge and/or experience in educating caregivers or direct care staff, or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with vision impairment or legal blindness, in sensitivity to low vision/blindness.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Certified Orientation and Mobility Specialists (COMS)	Administrative Service Organization	Annually
Human Service Agencies	Administrative Service Organization	Annually

Service Specification
Service Definition (Scope)**:** **Transitional Assistance Services**
Transitional Assistance services are non-recurring personal household set-up expenses for individuals who are transitioning from a nursing facility or hospital or another provider-operated living arrangement to a community living arrangement where the person is directly responsible for his or her own set-up expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) assistance with housing search and housing application processes, (b) security deposits that are required to obtain a lease on an apartment or home; (c) assistance arranging for and supporting the details of the move; (d) essential personal household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (e) set-up fees or deposits for utility or service access, including telephone service, electricity, heating and water; (f) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (g) moving expenses; (h) necessary home accessibility adaptations; and, (i) activities to assess need, arrange for and procure needed resources related to personal household expenses, specialized medical equipment, or community services. Transitional Assistance services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Transitional Assistance services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Transitional Assistance services include only those non-recurring set up expenses incurred during the 180 days prior to discharge from a nursing facility or hospital or another provider-operated living arrangement to a community living arrangement or during the period following such a transition during which the participant is establishing his or her living arrangement. Home accessibility adaptations are limited to those which are initiated during the 180 days prior to discharge. Transitional Assistance services may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed		
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Certified Business

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Certified Business		Certified Business	Will meet applicable State regulations and industry standards for type of goods/services provided.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Certified Business	Massachusetts Rehabilitation Commission	Annually or prior to utilization of service

Appendix C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The Massachusetts Executive Office of Health and Human Services (EOHHS), the single State Medicaid Agency, convened an interagency workgroup to address how best to comply with the requirements of the federal Home and Community Based (HCB) settings requirements at 42 CFR 441.301 (c)(4)-(5). The Massachusetts Rehabilitation Commission (MRC), an agency within EOHHS that has primary responsibility for day-to-day operation of the MFP-CL waiver, was a member of the workgroup. MRC undertook a review of all their regulations, standards, policies, licensing requirements, and other provider requirements to ensure compliance of settings with the new federal requirements, as they apply within this waiver. The MFP-CL waiver supports individuals who reside in either their own home or an apartment and may receive the following waiver services outside their home: day services, supported employment, and prevocational services settings (non-residential settings).

MRC's review and assessment process for these non-residential settings included: a thorough review of regulations, policies and procedures; waiver service definitions; provider qualifications and quality management and oversight systems to determine whether the systemic infrastructure was consistent with the principles of community integration; development of an assessment tool ~~that will borrow substantially from the~~based on the exploratory questions that CMS published; and review of the existing non-residential settings to determine if these settings meet standards consistent with the HCB settings requirement.

As detailed in the Site-Specific Assessment section and summarized in Table 2 of the STP submitted to CMS in September 2016, six out of seven MRC-contracted day services providers and seven out of eight MRC-contracted supported employment providers have been determined by MRC to comply fully with the Community Rule. The systemic and site-specific review processes MRC undertook to determine these providers' compliance status are summarized in Main Module Attachment #2 and described in detail in the Systemic Assessment and Site-Specific Assessment sections of the STP.
~~MRC continues to review waiver service settings to ensure compliance in the areas of these non-residential settings. The state will submit an addendum to its Statewide HCBS Transition Plan, as appropriate, during the next several months (see Main Module Attachment #2).~~

MRC conducts annual site visits of non-residential day services settings not licensed or certified by the Department of Developmental Services (DDS). For all such day services, MRC will utilize a

monitoring tool to review each site and the activities/services provided for all day programs to monitor ongoing Community Rule compliance. Supported employment provider qualifications are reviewed every two years to ensure continued compliance with requirements. In addition, MRC case managers monitor provider compliance through annual meetings with participants as part of the person-centered planning process.

If any of the ongoing monitoring indicates a need for a substantive change in the transition plan, MRC along with MassHealth will revise the STP, complete public input activities as described in Main Module Attachment #2, and resubmit the STP for CMS approval.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request):*

●	**Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
○	**No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○	**Yes. The State requests that this waiver be considered for Independence Plus designation.**
●	**No. Independence Plus designation is not requested.**

Appendix E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Subject to the limits to be described in the waiver application, participants in this waiver may lead the design of their service delivery through participant direction. The Case Manager will provide consumer-directed service options for participants who choose to self-direct one or more of services within their Plan of Care (POC) and to have choice and control over the selection and management of waiver services and providers. Participants may choose employer authority which will provide participants the opportunity to hire, manage and dismiss their own workers for certain services. Once eligibility has been established, and as part of the initial and on-going planning process of assessment and enrollment into the waiver, the individual is provided information by the Case Manager about the opportunity to self-direct. The Case Manager will describe the responsibilities of employer authority, the role of representatives and the availability of skills training and support for those choosing a participant-directed model of care.

Each year at the time of the Plan of Care (POC) development process, participants will be given the opportunity to self-direct certain services as specified in this application. The Case Manager will assess, based on established criteria, the participant's ability to self-direct and what supports may be needed to ensure success.

Each individual who self-directs will have a Case Manager to assist him/her to develop the waiver plan of care, and assist him/her to direct and manage that part of their plan of care that will be self-directed. The Case Manager will assist individuals to access community and natural supports and advocate for the development of new community supports as needed. The Case Manager will ensure that the participant receives necessary support and training on how to hire, manage and train staff and to negotiate with

service providers.

A variety of supports are available to assist participants who choose this model. The Case Manager determines whether the participant is able to carry out the responsibilities of an employer without assistance. Participants who require assistance must appoint a representative. Any participant may elect someone to act as his or her representative and assume responsibility for employer functions that the participant cannot or chooses not to perform. The Case Manager assists the participant and/or representative in POC development, identification of worker tasks and completion of required forms. In addition the Case Manager will provide or arrange for skills training to the participant and/or representative on employer functions and will link them to other needed resources such as worker training.

Individuals who self-direct and hire their own workers will sign an Agreement for Self Directed Supports and have the authority and responsibility as follows: recruit and hire workers, verify qualifications, determine workers duties, provide training and supervision, evaluate staff, maintain and submit time sheets, paying the worker, submit employee data to the Fiscal Management Service Agency (FMS) as required, and, if necessary, terminate a worker's employment. Once the POC is complete, information regarding the authorized frequency and duration of the participant-directed services in the POC is forwarded to a FMS.

The FMS performs the payment tasks associated with the employment of a participant's waiver service worker. The participant functions as the common law employer, while the FMS provides fiscal services related to income tax and social security tax withholding and state worker compensation taxes. The FMS assists participants in verifying worker citizenship status and conducts the Criminal Offender Record Information (CORI) check. The FMS collects and processes the participant's time-sheets.

The FMS will issue appropriate checks in the name of the worker and will mail the check to the MFP waiver participant who will distribute check to the worker. The worker may elect to have the FMS direct deposit payment into the worker's bank account in which case, the participant will notify the FMS to do so.

The FMS is responsible for tracking time worked to enable MassHealth to calculate payments to be made in accordance with FLSA requirements, including but not limited to payments for overtime.

The FMS is required to be utilized by participants and families who choose to hire their own staff and self-direct some or all of their waiver services in their POC. Each calendar year, there must be one FMS entity that is related to each worker in order to comply with IRS tax code requirements. The FMS functions will be recognized as administrative costs.

APPENDIX I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The rates for all MFP waiver services except the capitated Behavioral Health Diversionary Services (Addiction Services, Community Crisis Stabilization, Community Psychiatric Support and Treatment and Medication Administration) have been established by the Executive Office of Health and Human Services (EOHHS) with the assistance of rate analysis from Center for Health Information and Analysis (CHIA). The rate development process starts with an analysis of available data that may include but not be limited to provider cost, labor and other economic market information, utilization and public agency spending data. A cost adjustment factor is added to account for projected inflation anticipated during the prospective rate period. If appropriate, the data is adjusted to reflect desired economic efficiencies, such as productivity expectations and administrative ceilings. The process includes at least one consultative session to receive input from service providers. In addition, EOHHS has a public hearing for all rate regulations it proposes. Before the public hearing date, there is a public notice that includes the hearing date, time, location and the proposed rates. The public is welcomed to comment in person and/or in writing.

EOHHS is in the process of reviewing the MFP waiver rates according to the process described above. As part of this process, EOHHS is considering consolidation of the ABI and MFP rate regulations into one HCBS rate regulation.

The MFP waiver rates can be found in EOHHS MFP waiver services regulations 101 CMR 357.00. The regulation can be found on the MassHealth website: www.mass.gov/eohhs/gov/departments/masshealth/.

For Homemaker, Personal Care, Respite, Supported Employment, Adult Companion, Chore Service, Day Services, Home Accessibility Adaptations, Individual Support and Community Habilitation, Specialized Medical Equipment, and Transportation services the existing rates for ABI Waiver services established in the EOHHS regulation at 114.3 CMR 54.00 was utilized. Skilled Nursing services, Occupational, Physical and Speech Therapy services, self-directed Personal Care services and Home Health Aide rates are established based on the comparable state plan Medicaid service rates as established by EOHHS. For other services, such as Prevocational Services, Community Family Training, Independent Living Supports, Peer Support, Shared Home Supports, Supportive Home Care Aide and Vehicle Modification, CHIA developed new rates, as outlined above including utilizing an amalgamation of existing rates for comparable service components based on projected units per week, and analysis of provider cost data to establish the rate. All costs that are not eligible for federal financial participation, such as room and board, are excluded from the rate computation. Rates for Transitional Assistance services are based on the reasonable, allowable costs of goods and services provided. Rates for Orientation and Mobility services are based on the rates established for Money Follows the Person Demonstration Services in 101 CMR 356.00.

For the capitated Behavioral Health Diversionary Services, the state's actuary, Mercer, estimated expenditures based on recent experience of similar populations. Mercer estimated program expenditures for non-dual disabled clients between 19 and 64 years old and adjusted these expenditures, to account for the minimal expected cost impact of Medicare coverage.

The MFP case manager will inform the participant of the availability of information about waiver services payment rates and the EOHHS MFP waiver service regulations.

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care *(specify)*:	Hospital, Nursing Facility						
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1	16430.15	9421.01	25851.16	74414.35	3292.02	77706.37	51855.21
2	24605.77	14662.02	39267.79	115756.15	5120.94	120877.09	81609.30
3	28192.52	16856.28	45048.80	133014.75	5884.44	138899.19	93850.39
4	~~30421.26~~ 24683.27	~~18321.46~~ 16952.05	~~48742.72~~ 41635.32	~~144504.96~~ 133704.14	~~6392.75~~ 5914.94	~~150897.71~~ 139619.08	~~102154.99~~ 97983.76
5	~~32418.11~~ 27282.32	~~19485.03~~ 19212.56	~~51903.14~~ 46494.88	~~153604.87~~] 151456.91	~~6795.33~~ 6700.30	~~160400.20~~ 158157.21	~~108497.06~~ 111662.33

Appendix J-2: Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care: **Hospital**	Level of Care: **Nursing Facility**
Year 1	125	81	44
Year 2	240	156	84
Year 3	350	227	123
Year 4 (only appears if applicable based on Item 1-C)	~~464~~564	~~302~~149	~~162~~415
Year 5 (only appears if applicable based on Item 1-C)	~~579~~729	~~377~~193	~~202~~536

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-a.

The average length of stay for each year of the waiver reflects enrollment ramp up for new participants each year; once a person is on the waiver, we expect the average length of stay will be 338 days, based on experience with the populations in similar waivers. Therefore, in Year 1 the average length of stay is 169 days, which is half of the 338 days, an average of 5.5 months. This accounts for people entering the waiver year early in the waiver year and later in the waiver year. In subsequent years, waiver participants from the previous year are assumed to have an average length of stay of 338 days, and new participants are averaged at 169 days. Thus the average length of stay in Years 2, 3, 4, and 5 are 254, 282, ~~296~~274, and ~~304~~ 300 days respectively.

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D costs are based on the following:
- Number of Users: The estimated number of users for each waiver service is based on experience with other Massachusetts 1915(c) home and community-based service waivers that serve a similar target group with similar services, where applicable. For services that do not have a comparable waiver service, the estimated number of users is based on state agency experience with similar types of services for similar populations. We estimate that 90% of the 1915(c) waiver population will access a capitated behavioral health service via this concurrent 1915(b)/(c)

waiver. This is based on percentages of MassHealth populations that currently do not have access to managed behavioral health care, applied to our total waiver participant projections.

- Average Units per User: The average number of units per user for each service is based on the number of units per user for services included on other Massachusetts 1915(c) home and community based waivers that serve a similar target group with similar services, where applicable. The average units per user for Day services is based on the actual average units per person for this waiver reported in the most recent 372 (Waiver Year 4) with conversion from per diem to 15 minute units. For services that do not have a comparable waiver service, the estimated average units per user is based on state agency experience with similar types of services for similar populations. The enrollee expected utilization of the capitated services are based on utilization of a similar target group. As with all waiver services, this service is adjusted for the estimated average length of stay in each waiver year.

- Average Cost per Unit: The Division of Health Care Finance & Policy (DHCFP) established rates for waiver services are used where applicable. The following services are based on Rates for Acquired Brain Injury Waiver and Related Services 114.3 CMR 54.00: Individual Support and Community Habilitation, Day Services, Occupational Therapy, Physical Therapy, Speech Therapy, Skilled Nursing, ~~Community Based Substance Abuse Services,~~ and Supported Employment. As part of the rate review process for this waiver, EOHHS anticipates transitioning from per diem rates to 15-minute units in Prevocational and Day Services. The Skilled Nursing average cost per unit reflects a weighted average of the rate for 1-60 days and the rate for 61 days or more. ~~The Community Based Substance Abuse Services average cost per unit reflects an average of rates for applicable programs for the target population.~~ The average cost per unit for Family Training and Peer Support is based on the DHCFP approved SFY 2011 provisional rates for the Department of Developmental Services Waivers MA.0826 and MA.0827. The Home Health Aide average cost per unit is based on the DHCFP established rate in 114.3 CMR 50.00. The Orientation and Mobility average cost per unit is based on the rates established for Money Follows the Person Demonstration Services in 101 CMR 356.00. Transitional Assistance cost per unit reflects the average costs reported for Acquired Brain Injury waiver participants during the most recent 372 reporting period (ABI Waiver Year 4). For services that do not currently have a similar waiver service rate, or that are not rate based, average costs per unit were based on expenditures for similar services in state-funded programs in SFY 2011 or SFY 2012. The average cost per unit of the capitated units is based on our actuary Mercer's estimate of each individual service that will be delivered in a community setting to the target population.

- Trend: Rates described above, except for Behavioral Health Diversionary Services, are trended annually by 3.5%, the Consumer Price Index (CPI) rate, beginning in Waiver Year 2 and forward. There is no trend applied to base year waiver service rates forward to Waiver Year 1, as we do not expect the waiver service rates to increase during this time period. The capitated service cost is trended forward by 4.9% per year, based on Mercer's calculation of annual trend for these services. Mercer also applied a managed care savings adjustment of -2.4% to the base year SFY 2011.

The cost of services included in the capitation is calculated for each year by determining the aggregate cost of each service included in the capitation by the number of members we project will receive each service in the waiver. The cost of services not included in the capitation is calculated for each year by dividing the total amount for services not included in the capitation (all waiver services except the capitated services) by the number of members we project will enroll in the waiver.

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

○	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
●	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

ii. Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

	Waiver Year: Year 4 (only appears if applicable based on Item 1-C)						
Waiver Service / Component	Col. 1 **Check if included in capitation**	Col. 2 **Unit**	Col. 3 **# Users**	Col. 4 **Avg. Units Per User**	Col. 5 **Avg. Cost/ Unit**	 **Component Cost**	Col. 6 **Total Cost**
Home Health Aide	☐	15 min.	~~5668~~	~~1412.00~~ 1,306.00	6.76	~~534526.72~~ 600,342.08	~~534526.72~~ 600,342.08
Homemaker	☐	15 min.	~~195~~237	~~435.00~~ 403.00	5.62	~~476716.50~~ 536,771.82	~~476716.50~~ 536,771.82
Personal Care	☐	15 min.	~~167~~203	~~739.00~~ 684.00	5.62	~~693581.06~~ 780,348.24	~~693581.06~~ 780,348.24
Prevocational Services Total							~~781015.04~~ 135,686.64
Prevocational Services – per diem	☐	Per diem	~~326~~	~~84.00~~ 78.00	114.09	~~306673.92~~ 53,394.12	
Prevocational Services – 15 min	☐	15 min.	~~326~~	~~1298.00~~ 1,201.00	11.42	~~474341.12~~ 82,292.52	
Respite	☐	Per diem	~~93~~113	11.00	303.42	~~310398.66~~ 377,151.06	~~310398.66~~ 377,151.06
Supported Employment	☐	15 min.	~~323~~9	~~676.00~~ 625.00	9.49	~~205287.68~~ 231,318.75	~~205287.68~~ 231,318.75
Addiction Services	☑	15 min.	~~76~~92	33.70	17.41	~~44590.49~~ 53,977.96	~~44590.49~~ 53,977.96
Adult Companion	☐	15 min.	~~74~~90	~~689.00~~ 638.00	5.62	~~286541.32~~ 322,700.40	~~286541.32~~ 322,700.40
Chore Service	☐	15 min.	~~70~~85	~~80.00~~ 74.00	7.81	~~43736.00~~ 49,124.90	~~43736.00~~ 49,124.90
Community Crisis Stabilization	☑	15 min.	~~146~~177	9.07	37.67	~~49883.37~~ 60,475.04	~~49883.37~~ 60,475.04
Community	☐	15 min.	~~93~~	~~191.00~~	3.46	~~61459.98~~	~~61459.98~~

	Waiver Year: Year 4 (only appears if applicable based on Item 1-C)						
Waiver Service / Component	Col. 1 **Check if included in capitation**	Col. 2 **Unit**	Col. 3 **# Users**	Col. 4 **Avg. Units Per User**	Col. 5 **Avg. Cost/ Unit**	**Component Cost**	Col. 6 **Total Cost**
Family Training			113	177.00		69,203.46	69,203.46
Community Psychiatric Support and Treatment (CPST)	☑	15 min.	~~334~~ 406	16.57	32.11	~~177708.94~~ 216,017.46	~~177708.94~~ 216,017.46
Day Services Total							385,601.67
Day Services – Per diem	☐	Per diem	~~232~~ 23	~~88.00~~ 81.00	114.09	~~2329261.44~~ 212,549.67	
Day Services – 15 min.	☐	15 min.	23	1,800.00	4.18	173,052.00	
Home Accessibility Adaptations	☐	Item	~~14~~ 17	1.00	16630.77	~~232830.78~~ 282,723.09	~~232830.78~~ 282,723.09
Independent Living Supports	☐	Per diem	~~111~~ 135	~~296.00~~ 274.00	91.04	~~2991210.24~~ 3,367,569.60	~~2991210.24~~ 3,367,569.60
Individual Support and Community Habilitation	☐	15 min.	~~116~~ 141	~~676.00~~ 625.00	11.42	~~895510.72~~ 1,006,387.50	~~895510.72~~ 1,006,387.50
Medication Administration	☑	15 min.	~~41~~ 50	1.91	3.44	~~269.39~~ 328.52	~~269.39~~ 328.52
Occupational Therapy	☐	Visit	~~46~~ 56	~~42.00~~39.00	78.94	~~152512.08~~ 172,404.96	~~152512.08~~ 172,404.96
Orientation and Mobility Services	☐	15 min.	2	16.00	31.02	992.64	992.64
Peer Support	☐	15 min.	~~148~~ 180	~~973.00~~ 900.00	3.46	~~498253.84~~ 560,520.00	~~498253.84~~ 560,520.00
Physical Therapy	☐	Visit	~~116~~ 141	~~42.00~~ 39.00	75.72	~~368907.84~~ 416,384.28	~~368907.84~~ 416,384.28
Shared Home Supports	☐	Per diem	~~46~~ 56	~~296.00~~ 274.00	84.69	~~1153139.04~~ 1,299,483.36	~~1153139.04~~ 1,299,483.36
Skilled Nursing	☐	Visit	~~23~~ 28	~~42.00~~ 39.00	80.38	~~77647.08~~ 87,774.96	~~77647.08~~ 87,774.96
Specialized Medical Equipment	☐	Item	~~116~~ 141	1.00	2523.61	~~292738.76~~ 355,829.01	~~292738.76~~ 355,829.01

Waiver Year: Year 4 (only appears if applicable based on Item 1-C)

Waiver Service / Component	Col. 1 Check if included in capitation	Col. 2 Unit	Col. 3 # Users	Col. 4 Avg. Units Per User	Col. 5 Avg. Cost/ Unit	 Component Cost	Col. 6 Total Cost
Speech Therapy	☐	Visit	~~46~~ 56	~~42.00~~ 39.00	80.80	~~156105.60~~ 176,467.20	~~156105.60~~ 176,467.20
Supportive Home Care Aide	☐	15 min.	~~5~~ 6	~~730.00~~ 675.00	7.65	~~27922.50~~ 30,982.50	~~27922.50~~ 30,982.50
Transitional Assistance	☐	Per episode	78	3.00	3837.80	898,045.20	898,045.20
Transportation	☐	1-way trip	~~325~~ 395	~~165.00~~ 153.00	21.34	~~1144357.50~~ 1,289,682.90	~~1144357.50~~ 1,289,682.90
Vehicle Modification	☐	Item	~~14~~ 17	1.00	9239.32	~~129350.48~~ 157,068.44	~~129350.48~~ 157,068.44
						GRAND TOTAL:	~~**14115463.05**~~ **13,921,363.64**
						Total: Services included in capitation	~~272452.19~~ 330,798.98
						Total: Services not included in capitation	~~13843010.86~~ 13,590,564.66
						TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)	**464** **564**
						FACTOR D (Divide grand total by number of participants)	~~**30421.26**~~ **24,683.27**
						Services included in capitation	~~587.18~~ 586.52
						Services not included in capitation	~~29834.08~~ 24,096.75
						AVERAGE LENGTH OF STAY ON THE WAIVER	~~296~~ 274

ii. Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

	Waiver Year: Year 5 (only appears if applicable based on Item 1-C)						
Waiver Service / Component	Col. 1 **Check if included in capitation**	Col. 2 **Unit**	Col. 3 **# Users**	Col. 4 **Avg. Units Per User**	Col. 5 **Avg. Cost/ Unit**	**Component Cost**	Col. 6 **Total Cost**
Home Health Aide	☐	15 min.	~~69~~ 87	~~1450.00~~ 1,430.00	7.00	~~700350.00~~ 870,870.00	~~700350.00~~ 870,870.00
Homemaker	☐	15 min.	~~243~~306	~~447.00~~ 441.00	5.82	~~632174.22~~ 785,385.72	~~632174.22~~ 785,385.72
Personal Care	☐	15 min.	~~208~~ 262	~~759.00~~ 748.00	5.82	~~918815.04~~ 1,140,580.32	~~918815.04~~ 1,140,580.32
Prevocational Services Total							~~1067189.82~~ 232,972.20
Prevocational Services – per diem	☐	Per diem	~~41~~ 0	~~87.00~~ N/A	~~118.08~~ N/A	~~421191.36~~ N/A	
Prevocational Services – 15 min	☐	15 min.	~~41~~ 15	~~1333.00~~ 1,314.00	11.82	~~645998.46~~ 232,972.20	
Respite	☐	Per diem	~~116~~ 146	12.00	314.04	~~437143.28~~ 550,198.08	~~437143.28~~ 550,198.08
Supported Employment	☐	15 min.	~~41~~ 51	~~694.00~~ 684.00	9.82	~~279418.28~~ 342,560.88	~~279418.28~~ 342,560.88
Addiction Services	☑	15 min.	~~94~~ 148	34.97	17.76	~~58380.32~~ 91,917.95	~~58380.32~~ 91,917.95
Adult Companion	☐	15 min.	~~93~~ 117	~~708.00~~ 698.00	5.82	~~383212.08~~ 475,296.12	~~383212.08~~ 475,296.12
Chore Service	☐	15 min.	~~87~~ 109	~~82.00~~ 81.00	8.08	~~57642.72~~ 71,338.32	~~57642.72~~ 71,338.32
Community Crisis Stabilization	☑	15 min.	~~182~~ 286	9.35	38.42	~~65379.31~~ 102,738.92	~~65379.31~~ 102,738.92
Community Family Training	☐	15 min.	~~116~~ 146	~~197.00~~ 194.00	3.58	~~81810.16~~ 101,399.92	~~81810.16~~ 101,399.92

	Waiver Year: Year 5 (only appears if applicable based on Item 1-C)						
Waiver Service / Component	Col. 1 **Check if included in capitation**	Col. 2 **Unit**	Col. 3 **# Users**	Col. 4 **Avg. Units Per User**	Col. 5 **Avg. Cost/ Unit**	 **Component Cost**	Col. 6 **Total Cost**
Community Psychiatric Support and Treatment (CPST)	☑	15 min.	~~417~~ 655	17.05	32.75	~~232847.59~~ 365,743.81	~~232847.59~~ 365,743.81
Day Services Total							436,392.00
Day Services – Per Diem	☐	Per diem	~~290~~ 0	~~90.00~~ N/A	~~118.08~~ N/A	~~30881888.00~~ N/A	
Day Services – 15 min.	☐	15 min.	58	1,800.00	4.18	436,392.00	
Home Accessibility Adaptations	☐	Item	~~17~~ 22	1.00	17,212.85	~~292618.45~~ 378,682.70	~~292618.45~~ 378,682.70
Independent Living Supports	☐	Per diem	~~139~~ 175	~~304.00~~ 300.00	94.23	~~3981782.88~~ 4,947,075.00	~~3981782.88~~ 4,947,075.00
Individual Support and Community Habilitation	☐	15 min.	~~145~~ 182	~~694.00~~ 684.00	11.82	~~1189446.60~~ 1,471,448.16	~~1189446.60~~ 1,471,448.16
Medication Administration	☑	15 min.	~~52~~ 82	1.97	3.51	~~359.56~~ 567.01	~~359.56~~ 567.01
Occupational Therapy	☐	Visit	~~58~~ 73	43.00	81.70	~~203759.80~~ 256,456.30	~~203759.80~~ 256,456.30
Orientation and Mobility Services	☐	15 min.	8	16.00	31.02	3,970.56	3,970.56
Peer Support	☐	15 min.	~~185~~ 233	~~999.00~~ 985.00	3.58	~~661637.70~~ 821,627.90	~~661637.70~~ 821,627.90
Physical Therapy	☐	Visit	~~145~~ 182	43.00	78.37	~~488636.95~~ 613,323.62	~~488636.95~~ 613,323.62
Shared Home Supports	☐	Per diem	~~58~~ 73	~~304.00~~300.0 0	87.65	~~1545444.80~~ 1,919,535.00	~~1545444.80~~ 1,919,535.00
Skilled Nursing	☐	Visit	~~29~~ 36	43.00	83.19	~~103737.93~~ 128,778.12	~~103737.93~~ 128,778.12
Specialized Medical Equipment	☐	Item	~~145~~ 182	1.00	2,611.94	~~378731.30~~ 475,373.08	~~378731.30~~ 475,373.08
Speech Therapy	☐	Visit	~~58~~	43.00	83.63	~~208573.22~~	~~208573.22~~

	Waiver Year: Year 5 (only appears if applicable based on Item 1-C)						
Waiver Service / Component	Col. 1 **Check if included in capitation**	Col. 2 **Unit**	Col. 3 **# Users**	Col. 4 **Avg. Units Per User**	Col. 5 **Avg. Cost/ Unit**	**Component Cost**	Col. 6 **Total Cost**
			73			262,514.57	262,514.57
Supportive Home Care Aide	☐	15 min.	~~6~~ 7	~~750.00~~ 739.00	7.92	~~35640.00~~ 40,970.16	~~35640.00~~ 40,970.16
Transitional Assistance	☐	Per episode	78	3.00	3,837.80	898,045.20	898,045.20
Transportation	☐	1-way trip	~~405~~ 510	~~170.00~~ 168.00	22.09	~~1520896.50~~ 1,892,671.20	~~1520896.50~~ 1,892,671.20
Vehicle Modification	☐	Item	~~17~~ 22	1.00	9,562.70	~~162565.90~~ 210,379.40	~~162565.90~~ 210,379.40
						GRAND TOTAL:	~~**18770082.81**~~ **19,888,812.22**
						Total: Services included in capitation	~~356966.78~~ 560,967.69
						Total: Services not included in capitation	~~18413116.03~~ 19,327,844.53
						TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)	~~**579**~~ **729**
						FACTOR D (Divide grand total by number of participants)	~~**32418.11**~~ **27,282.32**
						Services included in capitation	~~616.52~~ 769.50
						Services not included in capitation	~~31801.58~~ 26,512.82
						AVERAGE LENGTH OF STAY ON THE WAIVER	~~304~~ 300